EXHIBIT G

STATEMENT

ABBAS KASHANI, M.D. P.O. BOX 500 BAYCHESTER STATION BRONX, NY 10469 Tel: 914/654-6543

Tax I.D. 060686325

STATEMENT DATE

PAGE

10/06/07

ACCOUNT NUMBER

7200831431 - 1 / SP

AMOUNT PAID \$

INDICATE

ladladddaladddddaladddddddddd

1-256

Saleh, Osama 7233 67th St Apt 3L Glendale NY 11385-6923

Detach and Return With Payment

Patient: SALEH, OSAMA

To assure proper credit detach the top portion and return with your remittance and/or see reverse side for instructions.

	1, OFFICE	3. OU	T-PATIENT HOSP	5. CLINIC	To Wi	o assure proper credit detach the th your remittance and/or see re	e top portion and return everse side for instructions.
*PLACE	2. IN-PATIENT	HOSP. 4. EM	PLACE PLACE		DESCRIPTION		TAUOMA
	DATE	D9 CODE	cones				0.00
}	 		1	Balance forward	last statement		150.00
09/	17/07	AK	ОН	99203 INITIAL (OFFICE/OUTPATIEN		
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	1						
	in the state of th						
		1 24575	UE AMOUNT	R	EFERRING PHYSICIAN	PLEASE PAY THIS	150.00
	. CURRENT AMOUNT	1	0.00	KASHANI, A	BBAS MD	AMOUNT	130.00
	, 150.00		0.00	1.2.2			

PLEASE REMIT PAYMENT DUE

ANY QUESTIONS PLEASE CALL 914/654-6543 EXT 114.

NOTE: PAYMENTS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT

YCKOFF EMERGENCY MEDICINE SERVICES O. BOX 500 AYCHESTER STATION **RONX, NY 10469** el: 914/654-6543

Tax I.D. 113495935

STATEMENT DATE

PAGE

10/06/07

ACCOUNT NUMBER

8300831431 - 1 / SP

Patient: SALEH, OSAMA

INDICATE AMOUNT PAID \$

3-729

Saleh, Osama 7233 67th St Apt 3L Glendale NY 11385-6923

Detach and Return With Payment

PLACE

1. OFFICE

3. OUT-PATIENT HOSP

8. CLINIC

To assure proper credit detach the top portion and return

DES 2. IN-P	,	MERGENCY ROO	and the second of the second o	and/or see reverse side for instructions.
DATE	ICD9 CODE	*PLACE CODES	DESCRIPTION	AMOUNT
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CURRENT AMOU	NT PASTO	JE AMOUNT	REFERRING PHYSICIAN	EASE
	0.00	0.00	KATARI, NAGENB MD	FASE THIS 330.0

PLEASE REMIT PAYMENT DUE

ANY QUESTIONS PLEASE CALL 914/654-6543 EXT 123.

NOTE: PAYMENTS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT WYCKOFF IMAGING SVCS, PC PO BOX 435 Lititz PA 17543

Master Card	HECK CARD USING FOR VISA DISC	COMPRESS
CARD NUMBER :		AMOUNT
SIGNATURE		EXP. DATE
STATEMENT DATE	PAYTHIS AMOUNT	ACCT.#
11/13/2007	520.QQ-10W	AMOUNT 131038
	PAID H	

ADDRESSEE



OSAMA SALEH 7233 67TH ST APT 3L GLENDALE NY 11385 WYCKOFF IMAGING SVCS, PC PO BOX 435 Lititz PA 17543

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side
 information has changed, and indicate change(s) on reverse side

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

	Patient Name			Insurance Balance		Patient Balance		Statement Date	Page
1	OSAMA SALEH		0.00		520.00		11/13/2007	1/1	
s D	ervice ate	Bill Number	Provider	Name T	Total Cha	rge	Payments Adjustments	Insurance Balance	Patient Balance
0	9/07/20	7 3151550	Anjana f	Patel	215.00		0.00	0.00	215.00
o	9/06/20	7 3151551	Jeffrey F	ischbein	305.00		0.00	0.00	305.00
Į.			Total Cha		52	20.00			
t				Paid by Insurance:		0.00			
Ę				Due from Insurance		0.00			
-			Please Pa	ny This Amount:	5	20.00	1		
Ç	urrent	30-60 Days	61-90 Day		120+ D 0.0		Total Balance	e Insurance Du	e Patient Due 520.00
	0.00	520.00	0.00	0.00	0.0	U	520.00	0.00	520.00

i. Please be advised that the Patlent Balance above is now your responsibility.

Kindly make your check payable to WYCKOFF IMAGING SVCS, PC and mail to the above address.

Si necesita ayude en espanol Por Favor Ilame al: (800) 605-1483

SERVICES WERE RENDERED AT:

Billing Questions: (800) 605-1483

WYCKOFF HEIGHTS MEDICAL CENTER

Office Hours: Monday - Friday 8:00 AM - 5:00 PM

	•		STATE	MENT		
WYCKOFF ANES P.O. BOX 500 BAYCHESTER ST BRONX, NY 1046 Tel: 914/654-6543	TATION 9	DICAL SERVICES,	Tax I.D. 113519417	STATEMENT DATE 10/06/07 ACCOUNT NUMBER 1600831431 - 1 / SP	PAGE	
		Patient: S	ALEH, OSAMA	INDICATE AMOUNT PAID \$		-
				halladlalalalalalala	ddaaddalladda	بالماماء
			1-119	Saleh, Osama 7233 67th St Apt 3L Glendale NY 11385-69	23	
PLACE 1. OFFICE	3. OU NT HOSP. 4. EA	JT-PATIENT HOSP 5. CI	Detach and Return	To essure proper credii detach tha r	DR Portion and relier	
DATE	ICD9 CODE	*PLACE CODES	DESCRI	with your remittance and/or see reve	arse side for instructions.	
09/10/07 09/21/07 PLEASE F 09/21/07 THIS BLL	MT PROVIDE INSU	Balance IH 21356 O	forward last statement		0.00 675.00	
09/21/07 PLEASE C	ALL 914/654-	5543 EXT 1 9 THANK	YOU			
į	!				1	

DATE	ICDO CODE	101.405	with your remittance an	erse side for instructions	
	ICD9 CODE	*PLACE CODES	DESCRIPTION		AMOUNT
09/10/07 09/21/07 PLEASE 09/21/07 THIS BU 09/21/07 PLEASE	L IS YOUR RES	PONSIBILI	TY		0.0 675.0
THOUGHT WAS A COLUMN TO THE CO					
URRENT AMOUNT 675.00	PAST DUE AM		REFERRING PHYSICIAN PLEASE MYINT, SOE MD PAY THIS		
ASE REMIT PAY	MENT DUE		AMOUNT		675.00

PLEASE REMIT PAYMENT DUE

ANY QUESTIONS PLEASE CALL 914/654-6543 EXT 123.

NOTE: PAYMENTS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT